

AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_, \_\_\_\_\_ hereby  
(name) (date of birth)

authorize \_\_\_\_\_  
(Name of Agency, program, or individual and title)

to disclose the following information from my records, (specify extent or nature of information to be disclosed):

\_\_\_\_\_  
\_\_\_\_\_

The purpose or need for such disclosure is: \_\_\_\_\_

\_\_\_\_\_

Medical records are protected by Federal Regulations, Kansas Statutes, and/or Administrative Regulations, and any further disclosure is prohibited without the undersigned's consent.

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

Specify the date, event, or condition upon which this consent expires:

\_\_\_\_\_

(If left blank, expiration date is sixty (60) days after the date entered below).

If applicable, disclosure made pursuant to this authorization shall be accompanied by a written statement regarding redisclosure as provided for by Federal Regulations 42 C.F.R. Part 2.

\_\_\_\_\_

(Signature)

\_\_\_\_\_

(Date)

Return the information being disclosed to:

**Authorized Representative of KSBEMS**

\_\_\_\_\_